Limited Benefit Plan Options in the Small Group Market

Prepared for The Maryland Health Care Commission





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Introduction

Providing affordable health insurance to millions of uninsured Americans is a top priority in Washington. The health care debate has focused on providing accessible, less costly health insurance to the millions of Americans who are uninsured – many of whom are unemployed or employed by small companies.

The Maryland Health Care Commission (MHCC) has been tasked by legislation to identify "potential options for allowing plans with fewer benefits . . . to be sold in the small group market, including the impact of any of the potential options." In 2007, MHCC conducted a comprehensive review of all aspects of the existing small employer health insurance market in Maryland. The review included an analysis of the potential for limited benefit health insurance to make adequate coverage more affordable for Maryland employers and employees who are currently insured but economically at the margin of dropping insurance, and the uninsured. Because of the recent recession and the continued deterioration of membership in this market, MHCC has asked Mercer to revisit this topic. ²

This paper examines separately two categories of limited benefit plans, identifies the pros and cons associated with each plan, documents the experience of other states that have authorized similar plans, describes the types of employers and employees interested in these plans and finally, provides the types of benefit plans that MHCC can expect to see for a maximum annual premium of \$2,500 for single-only coverage.

¹ Maryland SB 637/HB 674 (2009), "Health Insurance – Small Group Market Regulation – Modifications."

² Both Mercer and its sibling company, Oliver Wyman Actuarial Consulting, Inc., have participated in this analysis. For the purposes of this report, Mercer and Oliver Wyman Actuarial Consulting, Inc, are collectively referenced as "Mercer."

Maryland Health Care Commission

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Background

All states and the District of Columbia mandate that insured plans incorporate certain benefit features – for example, coverage of specific services and certain providers. These are collectively referenced as mandated benefits. The cost of providing mandated benefits varies by state and depends on the number of benefits mandated, as well as the level of benefits required.³

Seeking to encourage affordable options, legislators in forty-six states have authorized the sale of limited benefit plans that need not satisfy the state-mandated benefits requirements.⁴

Maryland legislators passed a bill, effective July 1, 2004, that enabled insurance companies in Maryland to offer limited benefit plans (LBPs) to certain small group employers. The LBP required all the services included in the Comprehensive Standard Health Benefit Plan but with some limitations on the amount of services. Because of its comprehensive design, the reduction in premium was negligible and therefore not popular in the small group market. The law expired June 30, 2008.

³ Recent studies in Maryland, Massachusetts and Texas have determined that most mandates each raise premiums by less than 1%. An earlier study by the Congressional Budget Office concluded that the five most expensive mandates each had a marginal impact on premiums, from 0.2% to 1.15%. Also, the Massachusetts study found that all mandates increased costs by only 3.4%. (Families USA, "Limited Benefit Plan: Expanding Coverage or Holding Our State Back?" October 2008). A similar comprehensive study, which was completed for Maryland mandated benefits and released in January 2008, found that the marginal cost of mandated benefits was 2.2%; however, the full cost of the mandate was 17.5% for small employers. The full cost of the mandates may be important for this discussion since some limited benefit plans (such as defined benefit plans discussed later) often do not cover the full scope of services required

http://mhcc.maryland.gov/health_insurance/mandated_1207.pdf.

for comprehensive major medical plans. The Maryland study can be found at

⁴ L. Quincy, "State Policies to Encourage High-Deductible and Limited-Benefit Health Plans: Costs, Constituents and Concerns." Mathematica Policy Research, Inc., Policy Brief, March 2009.

What Is a Limited Benefit Plan?

A limited benefit plan provides less benefit than a typical comprehensive medical/surgical plan, such as a low deductible plan typically offered by large, self-insured employers. There are several ways the benefit may be reduced:

- patient cost-sharing may be increased by increasing copayments or coinsurance for certain services;
- the total annual benefit available under the plan may be capped at a relatively low amount:
- the annual benefit for a given service may be limited;
- coverage for a given service may be excluded altogether; or
- patient cost-sharing may be increased by increasing the deductible.

The first method may be used in **value-based benefit designs** (described in a companion report from MHCC to the General Assembly) and may also be used in limited benefit plans. The next three methods characterize **defined benefit plans**. The last method characterizes **high-deductible health plans** (HDHPs).

Defined Benefit Plans

Benefits Provided

Defined benefit health plans typically provide: (1) specified payments for a defined number of medical occurrences each year, per service category or in total; or (2) utilize a dollar maximum, per service or in the aggregate. Products are designed to provide *income* protection, not *asset* protection. For the most part, defined benefit plans cover office visits, preventive care, diagnostic tests and x-rays, hospital confinement, and prescription drugs. In most cases, all of these services are capped at a fixed limit. While there appears to be no standard exclusion, various limited service arrangements exclude or limit reimbursement for hospital care, emergency or long-term treatment of unexpected major illness, surgical procedures, brand name drugs and all services exceeding modest coverage limits (e.g., \$2,000 – \$10,000). Some include pre-existing condition limitations; others do not.

Some combination arrangements couple the fixed-dollar features of the limited benefit arrangement with catastrophic protection, after satisfaction of a substantial corridor deductible – for example, first dollar coverage of certain services and catastrophic protection only after satisfaction of, say, a \$5,000 deductible.

⁵ M. J. Frase, "Benefits Agenda: Minimalist Health Coverage." HR Magazine vol. 54, issue 6, June 1, 2009.

The following shows the different approaches that several carriers have taken:

Aetna – Available maximums from \$2,000 – \$20,000; the \$2,000 plan provides reimbursement up to \$1,000 for hospital and emergency care, up to \$400 for diagnostic tests, up to \$200 for prescription drugs, and five covered office visits.⁶

AmWINS – Offers a corridor product with limited first dollar benefits and optional catastrophic protection in excess of a substantial deductible.⁷

Blue Cross Blue Shield of Florida – Several available options, such as plan features that include a \$1,000 deductible, \$25 copay for doctors' office visits (limited to six annually), 70% benefit, a \$750 hospital admission copay, and an overall annual maximum of \$10,000.

Century – Plan options provide \$20 - \$25 for office visits, \$20 - \$1,000 for tests, \$100 - \$500 per day for hospital services, and \$50 - \$500 per day for emergency room services.

CIGNA – Available maximums from \$25,000 – \$100,000 annually, with reimbursement for hospital services limited to \$750 per day, and for intensive care, \$2,000 per day. ¹⁰

Colonial Life – Five benefit components with some design flexibility; may cover doctors' office visits, preventive care, diagnostic tests and x-rays, prescription drugs, and hospitalization. ¹¹

Rocky Mountain Health Plans – Does not cover mammography, prostate screenings, mental health, alcoholism, hospice care \dots ¹²

The following table summarizes the popular defined benefit options underwritten by Aetna ¹³. AmWINS ¹⁴ and CIGNA. ¹⁵

⁸ Appleby

¹² Families USA (see note 3).

⁶ Julie Appleby, "Is a Little Medical Coverage that Much Better than None?" USA Today, June 5, 2007.

⁷ Appleby

⁹ Appleby

¹⁰ Appleby

¹¹ Frase

¹³ Aetna Affordable Health Changes Limited Benefits Information, Aetna Health Plan, 2009.

¹⁴ HealthWINS: A Limited Medical Insurance Plan for You and Your Family, AmWINS Group Benefits, May 2008.

¹⁵ Strategies Limited Benefit Health Plans Standard Medical Plans, CIGNA Indemnity, August 2009.

	<u>Aetna</u>	<u>AmWINS</u>	<u>CIGNA</u>
Doctors' Office Visits	In-network: 5 visits, \$10 copay, 100%; Out-of-network: 5 visits, \$10 copay, 80%	\$75/visit, 5 visits	Illness: \$15 copay, 100%; Accident: \$100 ded., 80%, 2/year \$5,000/occurrence max. \$10,000/year max.
Diagnostic, Surgical and Other Outpatient Services and Supplies	In-network: \$400 or 5 services per year, \$15 copay, 100%; Out-of-network: \$400 or 5 services per year, \$15 copay, 80%	Surgical: 100% RBRVS Maximum: \$2,500 Diagnostic X-ray: \$50/procedure, 2/year; \$100/MRI, 1/year	Additional in hospital surgery: 100%, \$2,500/year Additional maternity: 100%/\$2,500/year Outpatient care: \$100/year deductible, 80%, \$1,500 max.
Preventive Visits	In-network: \$100/year, \$15 copay, 100%; Out-of-network: \$100/year, \$0 copay, 50%	\$100, 1 visit	\$20 copay, 100%, \$100/visit, 1/year
Emergency Room Visits and Ambulance Services	\$1,000/year, \$100 deductible, 100%	ER: sickness \$100, 1 visit Ambulance: \$100, 1 occurrence Medical accident: up to \$2,500	Accident: \$100 deductible, 80%, 2/year
<u>Inpatient Charges</u>	In-network: \$10,000/year, \$250 ind./ \$500 fam. deductible, 80%* Out-of-network: \$10,000/year, \$250 ind./ \$500 fam. deductible, 60%*	\$2,000 first day \$4,000/day 10 days/year max.	100%, \$5,000/year max.
Prescription Drug	\$50/year, \$10 copay, 100%	\$15 generic only \$200/month max. \$50 annual deductible	\$15 generic copay/\$30 preferred brand, 100% \$600 max./year
Other		AD&D: \$5,000 Critical illness: \$5,000	AD&D: \$25,000

 $[\]ast$ There is a \$1,000 annual limit on hospital charges except charges for room and board and inpatient professional services.

Many plans are materially less rich than those listed for the major carriers. The following typifies these more restricted plans. This benefit package is currently being marketed in Maryland by SecureCare and underwritten by ACE Insurance.

	Value Plan Pays	Standard Plan Pays	Enhanced Plan Pays
Doctors' Office Visits (limit 5 visits per year)	\$30 visit	\$40 visit	\$50 visit
Outpatient Lab & X-ray (limit 3 visits per year)	\$30 visit	\$40 visit	\$50 visit
Wellness Visits (adult: 1 visit, children through age 4: 3 visits)	\$30 visit	\$40 visit	\$50 visit
Emergency Room (sickness only) (limit of 3 visits)	\$75 visit	\$100 visit	\$125 visit
Hospitalization (up to 100 days, double benefits for ICU)	\$200 day	\$350 day	\$500 day
Surgery inpatient outpatient	\$1,000 \$400	\$1,500 \$600	\$2,000 \$800
Vision Care (1 exam per year, glasses or contacts every 2 years)	\$25 \$50	\$25 \$50	\$25 \$50
Prescription Drug Discount Card	Included	Included	Included

The Marketplace

The list of companies that underwrite defined benefit plans is challenging to assemble. There are different forms of limited benefit arrangements that do not fit the definition, e.g., hospital income, specified disease, and separating one from another is difficult. Counting the various Blue Cross Blue Shield plans as one plan, we estimate that there are perhaps 25 companies underwriting these plans, including some of the larger health care plans. Many of these have products only covering groups with 51 or more employees. The list includes these and others:

- Aetna
- ACE Insurance
- AmWINS
- Several Blue Cross and Blue Shield Plans
- Century Health
- CIGNA¹⁶
- Colonial Life
- Rocky Mountain Health Plan¹⁷

Several insurers, including CIGNA, Aetna and ACE, already underwrite defined benefit plans in Maryland for employer groups with 51 or more employees.

Presumably, the decision to exclude small groups in most jurisdictions is a marketing and underwriting decision. In other words, it is not clear that authorizing "mandate-lite" defined benefit products in Maryland would lead to a significant increase in small group and individual marketing activity in Maryland. However, the current economic environment may increase the interest in these types of products, and the ability to expand offerings may lead to incremental additional products in the marketplace and an increase in the take-up rate by employers and employees. Moreover, individuals employed by small businesses that do not provide a group policy have an option to purchase fixed indemnity insurance on their own.

Characteristics of Participants in Defined Benefit Plans

Generally, businesses with the following characteristics are expected to benefit from these plans:

• *Employers with high staff turnover*. These plans can serve as the employer's sole option, as one of several options, or as a stopgap until employees satisfy certain service requirements for eligibility for more comprehensive benefits.

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¹⁶ Appleby

¹⁷ Families USA

- Employers with many hourly and part-time workers. Part-time workers are often excluded from participation in comprehensive plans for financial reasons, and low-paid employees may have difficulty making substantial contributions for comprehensive benefits.
- Employers that have difficulty affording the cost of comprehensive plans.

Examples of industries that would seem to be well suited for these plans include:

- Retail industry: department, specialty, convenience and grocery stores
- Restaurants: fast food, full service
- Hotels
- Health care: nursing homes, home health care services
- Professional services: security guards, call centers, staffing.

CIGNA¹⁸ and Aetna¹⁹ reported the following information about their defined benefit plan participants:

	<u>Aetna</u>	CIGNA
Average Participant Age	35 - 38	31
Average Annual Salary	Not available	\$38,000
Gender	50% female	56% female
Health Condition	Not available	Not available
Enrollment Status	75% - 80% employee only	Not available

A study of Utah's PCN, a state-subsidized defined benefit plan, indicates that its participants (1) are of various ages, (2) have very low incomes for the most part, and (3) are often in poor health.²⁰

Prevalence of Defined Benefit Plans

While statistics are not readily available, the estimates for the number of individuals with limited benefit policies range between one million ²¹ and two million individuals. ²² The 2008 Mercer's National Survey of Employer Sponsored Health Plans showed that nationwide, only 1% of small employers (defined as 10-49 employees) offered defined benefit plans. Seven percent of employers with 500 or more employees nationwide and

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¹⁸ Private e-mail from Steven Linder, Regional Head of Sales, SRC, an Aetna Company, October 20, 2009.

¹⁹ Private e-mail from Greg Nelson, Vice President, Middle Market Sales, CIGNA Voluntary, 2009.

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²¹ "Worse Than Nothing: Limited Benefit Health Plans." *Desert Beacon*, July 1, 2009. http://desertbeacon.blogspot.com/2009/07/worse-than-nothing-limited-benefit.html

²² Limited Benefit.com, "What is a Limited Benefit?" Accessed September 18, 2009. http://www.limitedbenefit.com/what-is-limitedmed-plan.php

20% of jumbo employers (20,000+ employees) offered defined benefit plans to part time workers or workers still in their probationary periods.²³ The Mercer survey did not include any enrollment statistics for these types of plans.

The Pros and Cons of Defined Benefit Plans

Advocates in favor of defined benefit plans say that these plans:

- Provide coverage to folks who otherwise would not be covered. The experience of several state limited benefit programs illustrates this point: Texas' Consumer Choice Benefit Plan added 7,500 previously uninsured individuals by the end of 2007, Maine's Dirego Choice program enrolled 6,000 who were not previously covered by mid-2008, and Tennessee's CoverTN program had enrolled 18,000 previously uninsured by February 2009.
- Help "reduce turnover, absenteeism, and fraudulent Workers' Compensation claims."
- May "improve company image, increase morale and boost ... recruiting efforts."
- Enable covered participants to use network and other providers who previously may have turned away or redirected uninsured patients.
- Allow cost-sensitive small employers to offer health benefits that they would otherwise be unable to offer.
- Offer insured individuals access to discounted rates for provider services including, in some cases, dental and vision services that are not covered by the plan. Some insurers have negotiated rates with providers in conjunction with their network-based products. These negotiated rates are available in most instances to their limited benefit plan enrollees.
- Provide "dignity" for their clients. Enrollees now have an insurance card and are part of the "system."
- Respond to the specific wants of low-income employees. Some argue that lower-income individuals are less concerned about asset protection and more concerned about income protection.

²⁵ CIGNA Voluntary Promotional Materials, "Brokers – Why A Limited-Benefit Medical Plan." CIGNA Healthcare, 2006. www.cignaindemnity.com/agenda_brokers/brokers_why_limited_benefits

²³ 2008 Mercer's National Survey of Employer Sponsored Health Plans.

²⁴ Quincy

²⁶ CIGNA

- Enjoy greater price stability. Because of the indemnity approach, these policies are much more insulated from inflation than HDHPs or richer comprehensive-type policies. Assuming the current premiums are accurately priced, the primary upward pressure on rates for defined benefit plans consists of increases in utilization of services, but often these policies contain annual limits as to the number of services covered.
- Create a new, affordable coverage option for uninsured individuals. Lower premiums can expand coverage. One can argue some coverage is better than no coverage.

The Commonwealth of Massachusetts has attempted to define what is affordable. The following table summarizes its 2008 determination:

	Maximum
Income Range	Monthly Premium
\$31,213 - \$37,500	\$165
\$37,501 - \$42,500	\$220
\$42,501 - \$52,500	\$330

Other states are beginning to establish their own standards:²⁷

- Support employee choice and flexibility.
- Fill gaps in employer-sponsored plans.
- Provide a portable health insurance option in the face of decreased job security (if product is portable).

Critics point out that defined benefit plans:

Historically have not had significant enrollment in the small group and individual markets unless the premiums were subsidized by the state. In 1999, Minnesota authorized defined benefit arrangements, but no insurers participated. In 2005, Minnesota again authorized these plans with some changes. By early 2008, still no insurers had elected to participate. Similarly, in Maryland in 2004, certain insurers were required to offer defined benefit plans, but the plans were required to cover the same services as the Comprehensive Standard Health Benefit Plan. This lack of flexibility in plan design resulted in a very limited reduction in premium and after three years, two insurers had sold only two contracts, covering 14 employees. Montana's experience was similar, and its program was dropped. On the other hand, in Arkansas, where these plans have been subsidized since 2007, there are 4,500 participants. Programs in Tennessee and Utah, both subsidized, have 18,000 and 17,400 participants, respectively.

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²⁷ Shelly Tan Napel, et al., "State Reform Efforts in the Small Group Market: Past, Present, and Future." *Robert Wood Johnson Foundation, State Coverage Initiatives*, July 2009. http://www.statecoverage.org/files/SCI_report_small%20markets.pdf

²⁸ Reinhardt

- Contribute to underinsurance as employers drop comprehensive plans for limited benefit arrangements. This is reinforced by a study done for the Texas Department of Insurance reporting that only 11% of Texas' successful limited benefit plan enrollees in 2006 were previously uninsured.²⁹
- Could lead to consumer misunderstanding. It is very important that employers and employees fully recognize the limited benefits these types of plans provide. Consumer Reports cautions against purchasing these arrangements, citing low overall limits, no catastrophic protection, and limitless out-of-pocket expenses."30
- Have not been popular with insurers. While the number of insurers offering HDHPs is robust, substantially fewer insurers offer defined benefit plans. For both small groups and individuals, the marketplace is even more limited. Reasons often cited for this reticence are (1) the potential for adverse publicity due to the limited nature of the benefits, (2) the costs of administration and communication, and (3) low sales commissions.

Should there be a need for services beyond those covered under a defined benefit plan for the insured or the insured's dependents, those services might be available through existing state public programs.

²⁹ Napel

³⁰ ConsumerReports.org, "Seven Signs a Health Plan Might Be Junk." Consumers Union, May 2008.

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High Deductible Health Plans

Benefits Provided

The other category of limited benefit plans discussed in this paper is HDHPs. Although falling under the rubric of limited benefit plans, HDHPs retain most of the features of traditional health insurance plans – for example, provider networks, copays for certain services, medical management activities, first dollar preventive care, and mandated benefits – but requires the satisfaction of an up-front annual per person deductible (typically \$1,000 or more) before the individual is eligible for plan benefits. ³¹ Plans often incorporate family deductibles and individual and family out-of-pocket limits. It is important to note that HDHPs cover the same scope of services that traditional comprehensive major medical policies cover and that these plans are usually subject to the same insurance laws as traditional major medical policies, including mandated benefits, rating and underwriting regulations, consumer protections, etc. The major difference between these policies and traditional comprehensive major medical policies is the increased cost sharing required through the front-end deductible, and the resulting lowering of the premiums.

A federally qualified HDHP may be paired with health savings accounts (HSAs). These accounts are repositories for employer and employee contributions that can be used to cover eligible health care or other expenses in the current plan year or in future years. Throughout the rest of this report, HDHPs with or without HSAs are considered collectively as "HDHPs."

³¹ Federally qualified HDHPs require a minimum deductible for single contracts and a minimum deductible for family contracts (any contract including a dependent). These minimum deductibles are indexed to the medical CPI and adjusted annually. In 2009, the minimum deductibles were \$1,150 for single and \$2,300 for family. For 2010, the minimum deductibles are \$1,200 for single and \$2,400 for family. Federally qualified HDHPs also have out-of-pocket maximums. For 2009, these were \$5,600 for single and \$11,600 for family. For 2010, they are \$5,950 for single and \$11,900 for family.

HDHP participants are also (1) less likely to report a health problem, (2) less likely to smoke, and (3) more likely to report relatively high income.³² Specifically, HDHP participants who establish an HSA were found by the GAO to have higher than average incomes³³ whereas HDHP enrollees without an HSA were found in an NCHS study to have incomes similar to other health insurance enrollees.³⁴

From the employer perspective, the market for HDHPs is virtually the same as the market for traditional plans; the types of employers that offer traditional plans are also likely to offer HDHPs.

The Marketplace

Virtually every health benefit underwriter offers HDHPs in some or all markets. *America's Health Insurance Plans (AHIP)*, in its January 2009 survey of US health insurance carriers, notes that 96 health insurance plans reported coverage in HDHPs. Of those 96 health insurance plans, 70 reported enrollment in the individual market, 86 reported enrollment in the small group market, and 87 reported enrollment in the large group market. Sixteen of the plans have more than 100,000 members enrolled.³⁵

Prevalence of HDHPs

Since the introduction of HDHPs in the early 1990s, participation has risen steadily. According to a study by the Government Accountability Office, participation in HDHPs with HSAs increased significantly between 2004 and 2007, from 438,000 to 4.5 million individuals, or about 2% of the insured population. In 2008, 18% of all workers and 35% of covered workers in small businesses enrolled in HDHPs. As of 2009, enrollment has grown to over 8 million, or approximately 4% of the insured population. Approximately 30% of these were employed in small groups.

³² Quincy

³³ GAO

³⁴ Robin A. Cohen et al., "Consumer-Directed Health Care for Persons Under Age 65 Years of Age with Private Health Insurance: United States 2007." NCHS Data Brief, No. 15, March 2009. http://www.cdc.gov/nchs/data/databriefs/db15.pdf

³⁵ AHIP

³⁶ Government Accountability Office (GAO), "Health Savings Accounts: Participation Increased and Was More Common Among Individuals with Higher Incomes." Washington, DC, GAO-080474R, April 2008. http://www.gao.gov/new.items/d08474r.pdf

³⁷ GAO

³⁸ *America's Health Insurance Plans (AHIP)*, "January 2009 Census Shows 8 Million People Covered by HSA/High Deductible Health Plans." Washington, DC, May 2009. http://www.ahipresearch.org/pdfs/2009hsacensus.pdf

The Pros and Cons of HDHPs

Proponents for HDHPs point to the following:

- HDHPs provide protection against catastrophic health care costs. Some will assert this is the true purpose of insurance.
- HDHPs promote more effective health care utilization as financially motivated participants forgo unnecessary services. Compared with traditional plan participants, HDHP participants report (1) thinking about the cost when deciding to see a doctor or fill a prescription (74% of HDHP/HSA participants and 60% of HDHP-only participants, compared with 44% of traditional plan participants); and (2) asking for a generic drug instead of a brand-name drug (54%, 53% and 46%, respectively).
- Because these are insurance policies, participants enjoy the lower fees negotiated by health plans for covered services that are (1) below the deductible, and/or (2) part of the coinsurance requirements. Since Maryland has all payor requirements for hospitals, access to provider discounts does not have as much impact as in other states. However, access to physician discounts is still valuable.
- Affordable HDHP options allow some small employers to continue to offer health care protection and others to implement plans.
- For individuals who have the financial resources to cover the deductible, HDHPs can lower monthly bills by reducing the monthly premium.
- For the young and healthy, HDHPs may represent an affordable option; those nearer to Medicare age, who have money set aside to cover a potential deductible, might also benefit from the lower premiums.
- In addition to catastrophic protection, most HDHPs (84% of all HDHPs and 98% of employer-sponsored plans in 2007)⁴⁰ provide some type of first dollar preventive benefits.
- HDHP participants often have access to a wealth of care management and information resources that can help them manage overuse and underuse and limit unnecessary services. These programs have been subsequently extended to traditional plans, but the financial incentives of the HDHPs may make them more effective.
- When combined with an HSA, individuals and employers are eligible for tax benefits.

³⁹ R. Ostuw, "Findings from the 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey: Implications for Plan Sponsors." EBRI Notes vol. 29, no. 4, April 2008. http://www.ebri.org/pdf/EBRI_Notes_04-20081.pdf

⁴⁰ AHIP, "A Survey of Preventive Benefits in Health Savings Account (HSA) Plans, July 2007." Washington, DC, November 2007. http://www.ahipresearch.org/pdfs/HSA_Preventive_Survey_Final.pdf

Arguments against HDHPs include the following:

- Lower premiums do not necessarily mean lower health expenses. Increasingly, routine medical expenses (prescription medications, treatments for minor illness, etc.) can amount to hundreds of dollars and are paid 100% by the member until the deductible is met.
- HDHP participants are somewhat more likely to delay or avoid services because of cost.⁴¹ Forgoing necessary services today could lead to more costly services later in life.
- To date, consumers prefer traditional plans to HDHPs. Despite dramatic growth in the plans between 2004 and 2009, only about 4% of those insured are covered by HDHPs. Reported satisfaction levels are also lower. Approximately 64% of traditional plan participants indicate that they are "very satisfied" or "extremely satisfied" with their plan, compared with 48% of HDHP/HSA participants and 35% of HDHP-only participants.
- For employees who have limited discretionary income, the high deductible may deter the individual from accessing services unless the plan offers first dollar coverage for preventive care.
- The high deductible may be perceived by some employees as being too great; these employees may perceive these types of plans as being the same as having no insurance since they are unable to fund the deductible.

⁴¹ Ostuw

⁴² Ostuw



Modeling an "Affordable Premium"

Since the primary motivation for purchasing a limited benefit plan is the attractiveness of the premiums, MHCC asked Mercer to identify what type of benefits could be expected for an annual premium of \$2,500 per adult per year.

Methodology

We started with the average premiums reported by small group carriers for 2008 for PPO policies. This information was provided to us by MHCC. We adjusted this to reflect 2010 levels. A target loss ratio of 80% was assumed, which is very similar to the actual loss ratio reported by the small group carriers in Maryland for the PPO products in 2008. For this exercise, Mercer assumed that this target loss ratio would not change for a limited benefit plan. (One can certainly argue that the target loss ratio for limited benefit plans would be lower, as the fixed costs represent a higher percentage of premium).

For purposes of this exercise, we assumed that the corresponding premium for a family policy would be \$7,000, or 2.8 times the single-employee premium. This premium estimate is consistent with premium information provided for small employer groups on MHCC's website for various carriers.

We have used our proprietary pricing model (calibrated to the expected claims costs represented by the anticipated premium for Maryland) to price various benefit plans. However, it is very possible that the pricing models for the various companies will differ from Mercer's – which, in turn, could generate different combinations.

The analytical process was iterative. Mercer valued each schedule of benefits and then modified plan design and revalued until the benefit schedule fell within the \$2,500 per person cost guidelines.

Mercer developed two types of defined benefit designs and two types of HDHP, all of which should satisfy the \$2,500 premium criterion. For the defined benefit plans, we

provided a scheduled benefit as one example. The second example is a straight 70% coinsurance plan up to an annual maximum with *no benefits after the annual maximum*. For HDHPs, one plan provides for a front-end deductible with no coinsurance afterward, and the second one provides a lower front-end deductible, but with 50% coinsurance, until a specific out-of-pocket maximum is reached. These examples are given to provide MHCC with an estimate of the type of cost sharing and/or limits on benefits that are necessary to achieve the targeted premium, and to demonstrate that there are different approaches to accomplishing this.

Defined Benefit

Scheduled Benefit Design

Outpatient Accident and Sickness

- Doctor's office visit: \$100/visit (max. 5/yr.)
- Wellness/well-child: adult \$100/visit (max. 1/yr.); children 4 and under – \$100/visit (max. 3/yr.)
- Outpatient lab and X-ray: \$100/visit (max. 3/yr.)
- Emergency room (sickness only): \$250/visit (max. 3/yr.)

Inpatient Accident and Sickness

- Hospital confinement: \$1,000/day (max. 100/yr.)
- ICU: additional \$1,000/day (max. 30/yr.)
- Mental, nervous, and substance abuse: \$250/day confined (max. 30/yr.)
- Skilled nursing facility: \$250/day confined (max. 60/yr.)

Inpatient and Outpatient Surgery

- Inpatient: \$ 4,000 (max. 1/yr.)
- Outpatient: \$1,600 (max. 1/yr.)
- Anesthesia: 25% of surgery benefit (max. \$1,000/yr.)

Vision Care

- Eye exam: \$50/yr.
- Glasses or contacts: \$100 for either, every 2 years

Prescription Drugs

Discount card

or

Coinsurance Design

- No front end deductible
- 70% of eligible expenses are covered up to \$12,000/yr
- 100% coverage up to \$500 annually for eligible preventive services (no cost sharing)
- Discount card for prescription drugs

HDHP

- After \$10,000 per person annual deductible, plan pays 100% of eligible expenses (no maximum)
- Up to \$500 annually for eligible preventive services (no deductible)
- Includes prescription drugs

or

After \$5,000 per person annual deductible, plan pays 50% of the next \$15,000 of eligible expenses for a total out-of-pocket maximum of \$12,500.

After that, the plan pays 100% of eligible expenses

- Up to \$500 annually for eligible preventive services (no deductible)
- Includes prescription drugs

There are advantages and disadvantages to each approach for attaining an affordable plan. The two defined benefit approaches are quite different. Although both provide some type of first dollar coverage, the *scheduled benefit plan* has internal limits as to the dollar amount and the frequency of many types of services. The *coinsurance plan* does not have any limits on frequency or scope of services but may require higher cost sharing for some services, such as office visits. The coinsurance plan may be more susceptible to inflation than the scheduled plan, although the annual limit on benefits will provide some hedge against inflation. Many may perceive the first dollar coverage to be more valuable than catastrophic protection (even if this first dollar coverage does not cover the entire cost of the service) and value these types of policies as the gateway into the health care system, or keeping those currently insured who are at the economic margin of being able to continue incurring the cost of a more comprehensive plan.

From a purely actuarial perspective, HDHPs represent what we would call "true" insurance in that it provides protection against catastrophic health care costs and includes absolute out-of-pocket maximums. However, to get to the \$2,500 annual premium, the deductibles have to be very high – to the point where they would be viewed as desirable by only a very small portion of the population who has either medium to high incomes and/or significant assets to be able to fund the out-of-pocket costs. Other than for preventive benefits, HDHPs provide no first dollar coverage. Evidence suggests that many wage earners, especially low wage earners with little or no discretionary income, see little economic value in this type of policy.

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